

The Launch of SHARED VISIONS—NEW PATHWAYS

The future is now. On January 1, 2004, the Joint Commission officially launches its new accreditation process, **SHARED VISIONS—NEW PATHWAYS**. While elements of several components of the process went live in the fall of 2003, including the Priority Focus Process, the Periodic Performance Review, and the “Jayco”™ extranet, the new year marks the start of official accreditation surveys under the new process, making **SHARED VISIONS—NEW PATHWAYS** real to health care organizations.

SHARED VISIONS—NEW PATHWAYS is the culmination of an intensive review and redesign of JCAHO’s accreditation process from start to finish that began in 1999 as a continuous improvement initiative. The result is a complete paradigm shift from a process focused on survey preparation and score achievement to one of continuous systematic and operational improvement by focusing to a greater extent on the provision of safe, high quality care, treatment, and services.

The Joint Commission recognizes—as do health care organizations—the comprehensiveness of the revisions brought about by **SHARED VISIONS—NEW PATHWAYS**. This is a time of great change, which can bring with it discomfort as well as risks as new processes “go live.” To help with this transition period, JCAHO has sought and used input from health care organizations and key stakeholders every step of the way; increased and improved communications to the field about all elements of **SHARED VISIONS—NEW PATHWAYS**; trained and educated staff extensively, including surveyors; tested and retested all systems

involved; and put measures in place to mitigate the risks inherent in any process and system redesign.

The changes brought about by **SHARED VISIONS—NEW PATHWAYS** are comprehensive, affecting every aspect of the accreditation process, including the following:

- Acquisition and use of more in-depth information about health care organizations to help focus the survey (Electronic Request for Application for Accreditation, Priority Focus Process)
- Application of that information to the accreditation process (tracer methodology)
- More timely, efficient, and effective communications between JCAHO and health care organizations (“Jayco” extranet, automated e-mails, account representatives)
- Reformatting and clarifying standards to focus more directly on safety and quality, which, in turn, will increase their relevance and value (Standards Review Project)
- A more continuous accreditation process that will facilitate an organization’s incorporation of the standards into daily operations (Periodic Performance Review, including plans of action and measures of success; physician engagement)
- Accreditation decisions (scoring, decision process)
- Follow-up after the survey (Evidence of Standards Compliance, measures of success)
- Reporting on survey findings (Accreditation Report, Quality Report)

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SPECIAL REPORT



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Launch of SHARED VISIONS—NEW PATHWAYS (continued)

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Each of these improvements brings great opportunity to increase the value of accreditation to all health care organizations while improving the quality and safety of health care provided to the public—the heart of the Joint Commission's mission. (A table showing which accreditation programs are affected by which components of SHARED VISIONS—NEW PATHWAYS is included on page 3). Like any change of this magnitude, the transition will not be perfect and still more improvements will be made as a result of lessons learned during implementation of SHARED VISIONS—NEW PATHWAYS.

This Special Issue of *Joint Commission Perspectives* summarizes each of the main components of SHARED VISIONS—NEW PATHWAYS, updating information provided in this publication since the last Special Issue on this topic in October 2002 and subsequent issues throughout 2003. In addition, topics specific to implementing this initiative will be addressed. Information about the initiative is also included in the 2004 accreditation manuals, including a new chapter titled “SHARED VISIONS—NEW PATHWAYS: The New JCAHO Accreditation Process.” The Joint Commission Web site (<http://www.jcaho.org>) also provides information about the initiative, including streaming videos about each component of the process. Questions about any component of SHARED VISIONS—NEW PATHWAYS can be directed to sharedvisions@jcaho.org

The Joint Commission is pleased to present its new accreditation process, SHARED VISIONS—NEW PATHWAYS, and hopes that it will be a powerful tool to help health care organizations improve the care, treatment, and services they provide to the public. ▲

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A Message from the Joint Commission President

On January 1, 2004, the Joint Commission officially launches the final product of its SHARED VISIONS—NEW PATHWAYS initiative. We hope and believe that health care organizations will find the new accreditation process to be tailored to their specific characteristics and needs in providing safe, high-quality care. Through the Priority Focus Process, Joint Commission surveyors will arrive on-site with relevant information and knowledge about your organization and will use actual tracer patients to move through your hallways and experience, firsthand, the work you do in providing direct care for individuals in your community. The result should be a survey that focuses on the most significant dimensions of the care you provide to patients.

The entire accreditation process has also been modernized by integrating new electronic capabilities into state-of-the-art evaluation methods. We therefore expect the new accreditation experience to be more efficient, less paper intensive, and more user-friendly than in the past. The foregoing characterization of our new approach to accreditation does not originate with the Joint Commission; it is rather a synthesis of comments made by those organizations that have worked with us to pilot test the new accreditation process.

Re-invention in the spirit of continuous quality improvement is not new to the Joint Commission. A complete re-examination and recasting of the standards was undertaken a decade ago through the Agenda for Change initiative. When those revisions were introduced, the Joint Commission made a commitment to apply continuous quality improvement concepts to its own accreditation process, as well. The SHARED VISIONS—NEW PATHWAYS initiative reflects a major culmination of the ongoing efforts to honor this commitment.

As with any quality improvement undertaking, improvement is a continuing journey, and that will be true for the Joint Commission's new accreditation process as well. Even with the detailed redesign of our approach to accreditation and the extensive pilot testing of the new process, further refinements after initial implementation are inevitable. We are therefore counting on your constructive feedback. To that end the Joint Commission has completely revamped the tools and methods it will use to gather input and feedback on the new accreditation process. We ask you to help us continually improve so that we may provide you with the best accreditation process possible.

As we all move into the modern era performance evaluation, please know that the Joint Commission truly values your partnership and our shared visions for continuous improvement in the safety and quality of health care.

Dennis S. O'Leary, M.D., President
Joint Commission on Accreditation of Healthcare Organizations

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The mission of the Joint Commission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.

Launch of **SHARED VISIONS–NEW PATHWAYS** (continued)

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Program Applicability of New Process Components

Programs ¹	Components						
	Revised/ Reformatted Standards	PFP ²	PPR ³	ESC ⁴	MOS ⁵	Tracer Methodology	Decision Process/Rules
Ambulatory Care	✓	✓	✓	✓	✓	✓	✓
Assisted Living				✓	✓	✓	✓
Behavioral Health Care	✓	✓	✓	✓	✓	✓	✓
Critical Access Hospital				✓	✓	✓	✓
Health Care Network				✓	✓	✓	✓
Home Care	✓	✓	✓	✓	✓	✓	✓
Hospital	✓	✓	✓	✓	✓	✓	✓
Laboratory	✓	✓		✓	✓	✓	✓
Long Term Care	✓	✓	✓	✓	✓	✓	✓
Office-Based Surgery				✓	✓	✓	✓
Preferred Provider Organization				✓	✓	✓	✓

¹ Information on when certain components will be applied to specific programs will be published in future issues.

² Priority Focus Process

³ Periodic Performance Review

⁴ Evidence of Standards Compliance

⁵ measures of success

Standards Review Project Hits Its Mark

The first phase of the Joint Commission's Standards Review Project, which began in 2001 for the **ambulatory care, behavioral health care, home care, hospital, laboratory, and long term care** programs, culminated in the fall 2003 publication of clarified and reformatted standards for each of these programs in the 2004 and 2004–2005 comprehensive accreditation manuals (effective January 1, 2004).

Under **SHARED VISIONS–NEW PATHWAYS**, the Standards Review Project did the following:

- Removed redundant requirements
- Improved the clarity of standards
- Focused standards on issues of patient safety and quality of care
- Reduced requirements that could lead to unnecessary paperwork and documentation
- Reorganized some of the standards into new and revised functional chapters
- Identified “common” standards across manuals and created consistent standards language when similar requirements existed
- Created a new format for presenting standards in the accreditation manuals, which includes the standard,

in some cases a rationale with background information about the standard, and element(s) of performance with the actual requirements against which organizations will be surveyed

These goals were first met through the work of JCAHO staff and the Standards Review Taskforce for hospitals, made up of external experts in health care, including quality directors, CEOs, COOs, nurses, physicians, engineers, risk managers, and other leaders in health care, many of whom are or were members of JCAHO committees. Revised standards chapters were also reviewed by JCAHO's Professional and Technical Advisory Committees for each of the programs affected as well as by JCAHO's Standards and Survey Procedures Committee and the JCAHO Board of Commissioners.

Few new requirements were created through the Standards Review Project. In some cases, standards effective in one or more accreditation programs were deemed applicable to other programs and applied accordingly. In such cases, these requirements would be new to a particular program.

Two “new” functional chapters resulted from the project, which were formed by reorganizing standards

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Standards Review Project Hits Its Mark (*continued*)

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originally located in other chapters. The new “Provision of Care, Treatment, and Services” chapter is a combination and reorganization of standards previously located in the “Assessment,” “Care of Patients,” “Education,” and “Continuum of Care” chapters. This reorganization better reflects the integrated and cyclical process of care. The new “Medication Management” chapter is composed of some of the standards formerly in the “Care of Patients” chapter. These standards were pulled into their own chapter to reinforce the importance of managing medication systems and processes to improve patient safety and quality of care.

Phase I

In order to apply the revision process as consistently as possible to the largest accreditation programs, the manuals for the ambulatory care, behavioral health care, home care, hospital, and long term care programs were all updated for 2004 to coincide with the launch of [SHARED VISIONS—NEW PATHWAYS](#). Because the accreditation manuals are normally effective for two years and scheduled manual updates are usually alternated among the largest programs, the ambulatory care, laboratory, and long term care manuals are effective for one year only. To return to the regular alternating year schedule, these will be updated again for 2005–2006.

To give the field as much time as possible to review the revised and reformatted standards, a prepublication version of the standards was posted on the JCAHO Web site (<http://www.jcaho.org>) in June 2003, along with a crosswalk between the 2003 and 2004 standards. The standards were removed from the Web site when the accreditation manuals were published in September

2003. The crosswalks remain on the Web site and will be updated as needed to identify additions or deletions to the standards as well as to correct any errors that may have appeared in the manuals. Changes to standards or elements of performance are published in *Perspectives* and posted to the JCAHO Requirements page on the *Perspectives* homepage of the Joint Commission Resources Web site (<http://www.jcrinc.com>).

Phase II

The Standards Review Project for the critical access hospital and office-based surgery programs is currently underway, pursuing the same goals as phase one. The new 2005 accreditation manuals for these programs with revised standards will be published in the fall of 2004. ▲

Other *Perspectives* Articles Covering This Topic

“Check Web Site for Updates to Standards Crosswalk,” November 2003, page 11

“Revisions to Medical Staff Standards,” September 2003, page 4

“Revised Management of Information Chapter Approved for 2004,” June 2003, page 3

“Standards Review Project Nears Completion,” May 2003, page 6

“[SHARED VISIONS—NEW PATHWAYS](#) Update,” December 2002, page 4

“A New Approach to JCAHO Accreditation Standards,” October 2002, page 4

“Experts Taking a Hard Look at Hospital Standards,” July 2001, page 3

Have a Question? Call Your Account Rep!

The launch of an entirely new accreditation process is bound to raise some questions. Hopefully, this Special Issue of *Perspectives* answers them. But if you have additional questions please contact your JCAHO account representative, who will also be making calls to all accredited organizations to address [SHARED VISIONS—NEW PATHWAYS](#) issues. If you do not know who your account rep is, call 630/792-3007.



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A Quick Guide to Acronyms

The following SHARED VISIONS—NEW PATHWAYS terms and their commonly used acronyms are provided for your reference. The meaning and use of these terms are explained throughout this special issue.

Clinical/service groups—CSGs

Electronic application for accreditation—e-App

Evidence of Standards Compliance—ESC

Measures of success—MOS

Periodic Performance Review—PPR

Priority focus area—PFA

Priority Focus Process—PFP

PFP Clinical/Service Groups and Priority Focus Areas Focus Survey Process

Under JCAHO's new accreditation process, the Priority Focus Process (PFP) uses information about an individual health care organization to more clearly focus the on-site survey on priority areas of safety and quality of care at that organization. The PFP gathers data about an organization from multiple sources and analyzes the data using a set of defined, automated rules—turning the data into information surveyors can use to tailor the survey to the needs of that organization.

The PFP results in two areas of information key to focusing the on-site survey process under [SHARED VISIONS—NEW PATHWAYS](#). Once data gathered about a health care organization are fed through the automated rules of the PFP, the process identifies the top four clinical/service groups (CSGs) and priority focus areas (PFAs) for that organization. Surveyors will then use this information to guide their choice of individual tracers during survey to ensure a consistent approach to the initial survey process that is based on the uniqueness of that organization.

CSGs are groups of patients or services in distinct populations for which data are collected. CSGs were identified for each accreditation program offered by JCAHO based largely on data gathered in JCAHO's electronic application for accreditation, or e-App, on populations of individuals served or services offered as well as data available through external organizations, such as MedPAR for hospitals, OASIS for home care, and MOS for long term care. The identified CSGs were then reviewed by JCAHO staff with expertise in each accreditation program to ensure that the CSGs were representative of populations served or services provided and applicable to the programs.

PFAs are processes, systems, or structures in a health care organization that significantly impact the quality and safety of care and for which the Joint Commission has standards. Top PFAs may not necessarily be the processes the organization does most often. PFAs were identified from the JCAHO Office of Quality Monitoring database, expert literature, and expert opinions.

Data Use

Data on CSGs and PFAs will be made available twice to health care organizations and once to surveyors during an organization's accreditation cycle. An organization will receive a list of its top CSGs and PFAs when it receives access to its Periodic Performance Review (see article, page 7). Having these data may be useful as an organization embarks on completing the full PPR or option 1.

The organization will again receive its top CSGs and PFAs two weeks prior to its full accreditation survey. At this time, surveyors will also receive this information to begin to plan for the survey. (This process will change when Joint Commission surveys become unannounced in 2006.) The CSGs and PFAs will guide the surveyors in selection of initial individual tracers. During the survey, surveyors may change their focus depending on their findings on site.

Organizations may note some changes in their CSGs and PFAs from their first look to their second look 18 months later. These areas may change if JCAHO receives additional information about an organization over the following year and a half. Such information could be data from JCAHO's Office of Quality Monitoring, results of special surveys or random unannounced surveys, or new ORYX core measures or external data.

In the early implementation phase of [SHARED VISIONS—NEW PATHWAYS](#), individualized CSGs and PFAs may not be available for all health care organizations. Because CSGs are taken largely from data provided in an organization's e-App, CSG information may be incomplete if an organization has not previously submitted its application electronically. Moreover, the current e-App does not collect all data necessary to provide a comprehensive look at CSGs. Planned changes to the e-App to collect some additional data will help to address this issue.

In programs for which presurvey data are not as readily available, including long term care and home care, there may not be enough input to the PFP to result in individualized PFAs. For those organizations for which specific PFAs cannot be identified in this early phase, the top aggregate PFAs identified for that accreditation program will be listed for the organization and the surveyor.

PFP output data are listed in the box beginning on page 6 in the form of CSGs for each accreditation program and PFAs applicable to all programs, unless otherwise indicated. ▲

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Other *Perspectives* Articles Covering This Topic

"Clinical/Service Groups," October 2003, page 7

"Clinical/Service Groups for Hospitals," August 2003, page 9

"Implementing the Priority Focus Process," October 2002, page 8

Clinical/Service Groups and Priority Focus Areas (continued)

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Priority Focus Process Output

CLINICAL/SERVICE GROUPS BY ACCREDITATION PROGRAM

Ambulatory Health Care Medical/Dental

- Cardiology
- Dentistry
- Dermatology
- Emergency medicine
- Family practice
- Gastroenterology
- General practice
- Internal medicine
- Neurology
- Obstetrics/gynecology
- Occupational health
- Oncology
- Optometry
- Orthopedic medicine
- Otolaryngology
- Pediatric medicine
- Pharmacy/dispensary
- Podiatry
- Rheumatology
- Short stay/observation/infirmar y/recovery
- Urology
- Vascular medicine
- Surgery/Anesthesia**
 - Cardiac catheterization
 - Endoscopy
 - Gastroenterology procedures
 - General surgery
 - In vitro fertilization
 - Ophthalmology
 - Oral maxillofacial surgery
 - Orthopedic surgery
 - Plastic surgery
 - Podiatric surgery
 - Trigger point injections (pain management)
 - Urologic procedures
- Diagnostic/Therapeutic Services/Other**
 - Allergy
 - Alternative/complementary care
 - Audiology
 - Chiropractic medicine
 - Diagnostic imaging
 - Dialysis
 - Hematology

- Infusion therapy
- Lithotripsy
- Orthotics/prosthetics
- Pain management
- Physical medicine and rehabilitation
- Pulmonary medicine
- Radiation oncology
- Sleep diagnostics
- Waived laboratory testing
- Other

Assisted Living

- Activities/socialization
- Contracted health care services
- Hospitality support services
- In-house nursing care services
- Medication services
- Specialty service—Dementia
- Specialty service—Children/young adults
- Specialty service—Neurologic/TBI
- Specialty service—HIV
- Specialty service—Cosmetic surgery recovery
- Specialty service—Hospice
- Specialty service—Wound care
- Specialty service—Rehabilitation
- Specialty service—Other

Behavioral Health Care¹

- Adult day care
- Assertive community treatment
- Behavioral health services
- Case management
- Chemical dependency
- Correctional behavioral health
- Developmental disabilities
- Family preservation/wraparound services
- Forensic behavioral health
- Foster care
- In-home behavioral health

¹ Applies to both child and adult populations

- Methadone detoxification
- Methadone maintenance
- Outdoor behavioral health
- Post-acute acquired brain injury
- Shelter
- Therapeutic foster care
- Vocational rehabilitation

Critical Access Hospital

- Cardiology (core measure)²
- Dentistry
- Dermatology
- Endocrinology
- Gastroenterology
- General medicine
- General surgery
- Gynecology
- Hematology
- HIV infection
- Neonatology (core measure)
- Nephrology
- Normal newborns
- Obstetrics (core measure)
- Oncology
- Ophthalmology
- Orthopedics
- Otolaryngology
- Pediatrics (core measure)
- Psychiatry
- Pulmonary (core measure)
- Rehabilitation
- Rheumatology
- Substance abuse
- Thoracic surgery
- Trauma
- Urology
- Vascular surgery
- Other

Health Care Network

- Health Maintenance Organization (HMO)
- Integrated Delivery Network (IDN)

² As of July 1, 2002, hospitals are required to collect data on two of the four core measures identified in this list and to submit that data through a listed performance measurement system by January 31, 2003.

- Managed behavioral health care organization
- Continuing care services
- Specialty care—Behavioral health
- Specialty care—Physical therapy
- Specialty care—Pharmacy
- Specialty care—Podiatric
- Specialty care—Surgical/subspecialty
- Specialty care—Chiropractic
- Specialty care—Eye care
- Specialty care—Dental
- Specialty care—Pediatric
- Other

Home Care

Home Medical Equipment

- HME—Clinical respiratory services
- HME—Home medical equipment services
- HME—Rehabilitation technology

Hospice

- HOS—Facility-based respite care
- HOS—Facility-based symptom relief
- HOS—Hospice in-home care

Pharmacy

- RX—Clinical consultant pharmacist
- RX—Freestanding ambulatory infusion
- RX—Long term care pharmacy dispensing
- RX—Pharmacy dispensing

Home Health

- HH—Home health services
- HH—Home personal care/support services

Additional Home Health Based on CMS' Home Health Care Compare Data

- HH—Patients having acute care hospitalizations
- HH—Patients having confusion difficulties
- HH—Patients having emergent care

- HH—Patients having pain interfering with activity
- HH—Patients needing ambulation improvement
- HH—Patients needing bathing assistance
- HH—Patients needing oral medication management
- HH—Patients needing toileting assistance
- HH—Patients needing transferring assistance
- HH—Patients needing upper body dressing assistance

Hospital

Inpatient

- Cardiac surgery
- Cardiology (core measure)
- Dentistry
- Dermatology
- Endocrinology
- Gastroenterology
- General medicine
- General surgery
- Gynecology
- Hematology
- HIV infection
- Neonatology (core measure)
- Nephrology
- Neurology
- Neurosurgery
- Normal newborns
- Obstetrics (core measure)
- Oncology
- Ophthalmology
- Orthopedic
- Other
- Otolaryngology (core measure)
- Pediatrics
- Psychiatry
- Pulmonary (core measure)
- Rehabilitation
- Rheumatology
- Substance abuse
- Thoracic surgery
- Trauma
- Urology
- Vascular surgery

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Periodic Performance Review Key to Continuous Provision of High-Quality Care

The Periodic Performance Review (PPR) is integral to [SHARED VISIONS—NEW PATHWAYS](#) and key to achieving continuous standards compliance and, thus, continuous provision of safe, high-quality care. The PPR provides for a compliance assessment at the midpoint of an organization's accreditation cycle, preferably done by the organization itself. An option is available whereby the assessment is conducted by a Joint Commission surveyor(s). In addition to assessing compliance, an organization must develop a plan of action for any standard with which it is found to be out of compliance during the PPR and identify measures by which it will gauge its success in carrying out its plan(s) for those elements of performance designated with an "M" for measures of success in the accreditation manuals.

The PPR tool first became accessible on the "Jayco"TM extranet site November 1, 2003, for organizations due for survey on July 1, 2005. New organizations gain access every day going forward from November 2003 according to their survey due dates. A sample chapter of the PPR tool was provided on CD in all 2004 accreditation manuals for review purposes only. Organizations cannot use this disk to submit data.

PPR Methods

An organization currently has four choices for fulfilling its PPR requirement: the full PPR, PPR option 1, PPR option 2, and PPR option 3. The full PPR and its three options all take place at the midpoint in an organization's accreditation cycle (18 months after a triennial survey). Before an organization gains access to the PPR at the 15-month point in its accreditation cycle, JCAHO will notify an organization via e-mail that it must advise JCAHO no later than the 18th month of its cycle whether it intends to participate in the full PPR, option 1, option 2, or option 3. During that time, organizations are encouraged to review the PPR tool and discuss with their organization's leadership whether they will participate in the full PPR, or which PPR option they will ultimately choose. Organizations should be aware that if they enter any data into the PPR tool before selecting any option, that data will be available to the Joint Commission as a technical matter, even though JCAHO will not access that data or use it in the organization's accreditation process.

An organization will inform JCAHO of this choice by clicking on the appropriate entry in the PPR tool and submitting this to JCAHO. What the organization chooses dictates what it must do to fulfill its PPR requirement.

Full PPR

The full PPR process includes an organizational review of standards compliance at the midpoint in their accreditation cycle (18 months after a triennial survey) using JCAHO's automated tool. If the organization chooses to complete the full PPR and clicks on this selection, it will have access to the PPR tool on JCAHO's password-protected extranet site that is accessible only to that organization. Organizations will also be able to use this site to formulate plans of action for standards that are not compliant and identify measures by which the success of these plans can be evaluated. A User Guide for the full PPR is available as part of the PPR tool and is available on the JCAHO extranet (<http://www.jcaho.org/jaycohome/jaycohomepage.htm>).

At approximately 15 months after the organization's full survey, JCAHO will send an e-mail to the organization to announce that the PPR tool has been posted to its extranet site. JCAHO recommends that organizations open the tool within 10 days of posting. If the tool is not accessed within 30 days, a JCAHO account representative will contact the organization to provide assistance, if needed. An organization's account representative can also answer questions about the PPR.

The PPR tool will be customized for each organization, indicating which accreditation programs and standards apply to the organization, and will not allow the organization to submit its review until all standards are evaluated. Thus, if an organization has both a hospital and a home care component, the necessary standards for both settings will be included in the PPR. Through the assessment tool, the health care organization will score each element of performance (EP) related to the applicable standards.

For any standards found through the PPR to be not compliant, the organization will formulate a plan of action addressing each EP scored partial or insufficient compliance. This plan should state how the matter will be corrected and how the success of the plan of action will be evaluated, if a measure of success (MOS) is required. A special "References" section in the tool lists the rationales and EPs for required standards to help organization staff determine their level of compliance. User guidelines will also be available to aid in using the tool and constructing appropriate plans of action.

The same rules surveyors will use to determine standards compliance during the on-site survey are incorporated into the PPR tool. EPs that are scored as partially compliant but, because of aggregation rules, do not

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Periodic Performance Review Key to Quality Care *(continued)*

(Continued from page 7)

result in a standard-level decision of “not compliant,” will be listed in an ancillary report for the organization’s reference.

Once the organization assesses all standards compliance and formulates all plans of action, as needed, the organization will submit its PPR electronically by the due date, which is the 18-month point after the last full survey. Within a few days after the due date, a scheduler from JCAHO’s Standards Interpretation Group (SIG) will contact the organization to set up a date and time for the call to review all standards found to be not compliant. (Rules for determining when standards are not compliant appear on page 18 of this issue.)

The Review Session

Most telephone conferences will occur within 30 days after the PPR due date (or within 30 days after a late submission). The organization should allow up to four hours for the conference call and choose two people as representatives to speak with SIG staff. Although other staff may be present, JCAHO asks that only two people from the organization participate in the discussion at a time. The only criterion for the representatives is that they should be knowledgeable about the information in the PPR.

Before the telephone conference, SIG staff will review the organization’s PPR, background information, and any previous recommendations from triennial surveys to get additional background on the organization’s accreditation history. The organization does not need to prepare anything for the review session, although representatives should have a printout of the PPR with them during the session.

During the telephone conference, SIG staff and organization participants will go over each standard that is not compliant as identified in the PPR, along with the plan of action and MOS. The SIG representative may, as appropriate, make suggestions for additions or other changes. Based on this discussion, SIG staff will give official approval to plans of action that surveyors will not challenge in terms of design. If JCAHO staff members determine that the organization is actually compliant with a standard that the organization marked as not compliant, staff will note this on the plan of action and indicate that no plan of action is required in the report returned to the organization.

Some organizations may submit more plans than can be discussed in the time allotted for the review session. In such cases, the SIG staff member will focus on those plans that require discussion and comment on others in the written report given to the organization. This conversation can help organizations avoid unnecessary work that may be based on misunderstanding or erroneous advice about what compliance requires. During this call, SIG

staff members will also educate the organization on JCAHO’s new scoring guidelines.

After the telephone conference has been completed, the SIG representative will post the PPR, including his or her suggestions and changes from the review session, on the organization’s section of the extranet site. During the organization’s triennial survey, surveyors will review MOS data from the PPR.

Organizations choosing the full PPR will enjoy the benefits of organization-specific education from the SIG staff on standards compliance issues. Moreover, because an organization’s plans of action are approved by SIG, surveyors cannot overrule the makeup of these plans during the on-site survey. They will, however, check to see that organizations are implementing their plans appropriately and that the plans are resulting in the desired outcomes.

PPR Option 1

PPR option 1 still requires that organizations complete and affirm that they have completed an assessment of their compliance with applicable standards. They also must develop and affirm that they have developed plans of action and MOS, as necessary. However, they will not be required to submit their PPR data to JCAHO. An organization selecting this option will not be able to use the PPR extranet tool to score compliance with standards because JCAHO, as a technical matter, would then have access to the PPR information. However, the organization will be able to print the standards and EPs from the PPR tool from which to do its own assessment.

If an organization notes in the PPR tool that it chooses option 1, the organization must affirm in the tool that it has self-assessed compliance with all relevant standards, developed appropriate plans of action for identified areas of standards noncompliance, and identified MOS for all such standards, as required. The organization will also be required to affirm that, for substantive reasons, it has been advised by legal counsel not to participate in the full PPR.

The organization using PPR option 1 is not required to participate in a conference call with SIG, but it may submit standards-related issues for discussion, if it chooses to do so, without indicating its own level of standards compliance. During this call, no inferences about potential areas of standards noncompliance will be made, and official approval of process designs or redesigns will be given. If the organization doesn’t submit any issues for discussion, SIG will not schedule the phone call. During the on-site survey, surveyors will review MOS.

PPR Option 2

PPR option 2 provides an on-site survey conducted by JCAHO in place of any self-assessment activities by the

organization itself. Organizations choosing this option will be required to complete and submit to JCAHO plans of action within 30 days of survey for any standards for which they are out of compliance.

If an organization notifies JCAHO that it chooses PPR option 2 for an on-site survey at its midpoint, JCAHO will schedule the survey at the approximate midpoint in the organization's accreditation cycle. As with option 1, organizations choosing option 2 will need to affirm that they have been advised by legal counsel not to participate in the full PPR.

This survey will be approximately one-third the usual length of that organization's triennial survey and will usually be conducted by a single surveyor primarily using tracer methodology. It will be limited in scope and guided by the organization's Priority Focus Process (PFP) to address organization-specific issues. The organization will be charged a fee to cover the costs of conducting this survey.

If the surveyor finds the organization to be out of compliance with one or more standards during this midpoint survey, the organization will be required to submit a plan(s) of action with applicable MOS to JCAHO within 30 days of the survey. After the plan(s) is received, JCAHO will schedule in a conference call with SIG staff. During the call, JCAHO staff will discuss with the organization the appropriateness of its plans of action and MOS. As a result, the plans will be approved as is or as amended.

Like the full PPR and option 1, the organization that selects option 2 will share with JCAHO applicable MOS at its triennial survey.

PPR Option 3

As in PPR option 2, PPR option 3 is a mid-cycle on-site survey by the Joint Commission. However, with option 3, the JCAHO surveyor will leave no written report of the survey with the organization. Rather, the survey findings would be conveyed orally by the surveyor to organization staff at the end of the survey.

For full surveys of organizations choosing PPR option 3, surveyors will have the results of the mid-cycle assessment, but they will not address in the full survey the fact that any specific standards were found out of compliance during the mid-cycle survey unless the organization asks the surveyors to do so. Rather, surveyors will focus on compliance with all standards at the time of the full survey, including those that may have been out of compliance at the mid-cycle assessment. The organization will be charged a fee for this option.

In both PPR options 2 and 3 involving on-site surveys, the Joint Commission will invoke its Immediate Threat to Life policy and take immediate action should surveyors find anything on site that is having or may potentially have a serious, adverse effect on patient health or safety.

Physician Engagement in the Accreditation Process

Better engagement of physicians in the accreditation process has been a goal of [SHARED VISIONS—NEW PATHWAYS](#) from the beginning. Physicians, by the nature of their role, are in a unique position to share meaningful insight into opportunities for improvement in organization systems and processes and to provide leadership for other staff members in the accreditation process.

To further this goal, JCAHO has met with physicians on the new accreditation process to learn where their involvement would be most beneficial and appropriate. Physician focus groups indicated that they would prefer to be involved in the PPR and developing Evidence of Standards Compliance and MOS.

In support of this involvement, JCAHO's Accreditation Committee approved revisions for hospitals to the Accreditation Participation Requirement for the Periodic Performance Review, requiring that hospitals and medical staffs work together to demonstrate that physicians were appropriately involved in the PPR and plans of action (see revised APR language in box on page 10).

JCAHO will continue to work with physicians to identify ways physicians can provide valuable input to the accreditation process.

(The complete language of this policy is included in the "Accreditation Policies and Procedures" chapter of the accreditation manuals.)

Accreditation Status

For all four PPR methods, if the organization fails to submit its selection within 30 days of the due date, its accreditation status could change to Provisional Accreditation. Failure to submit in 60 days could result in Conditional Accreditation, and failure to submit within 90 days could result in presentation of the organization to JCAHO's Accreditation Committee with a recommendation for Denial of Accreditation. Because the PPR is an important component of [SHARED VISIONS—NEW PATHWAYS](#), the Joint Commission has made it an Accreditation Participation Requirement (APR). The text of this APR appears on page 10.

Legal Concerns

PPR options 1, 2, and 3 were developed to address concerns from the legal community and risk managers in health care organizations about the potential discoverability of self-assessment information. JCAHO formed a Legal Issues Task Force with representatives from the legal field, state hospital associations, and the American Society for Healthcare Risk Management (ASHRM) to discuss these concerns. (More information about these legal concerns is provided in the October 2003 *Perspectives*,

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Periodic Performance Review Key to Quality Care (continued)

(Continued from page 9)

page 1.) JCAHO continues to work with this task force to explore other possible options to the PPR.

It is an Accreditation Participation Requirement (APR) for an organization to participate in the PPR in one of the approved methods. Failure to meet this requirement (APR 14) can cause an organization ultimately to lose its JCAHO accreditation. Revisions to APR 14 were approved by JCAHO's Accreditation Committee in the fall of 2003 requiring the following:

- For organizations choosing PPR option 1, 2, or 3, they must affirm that after careful consideration with legal counsel, the organization has decided not to participate in the full PPR
- For hospitals only, the hospital, in concert with the medical staff, must demonstrate that physicians were appropriately involved in the completion of the PPR and development of plans of action.

These changes, shown in strikethrough and underline in the box below, are effective **July 1, 2004**, for ambulatory

care, behavioral health care, home care, hospital, and long term care organizations. The original APR for PPR, without the revised language, is effective January 1, 2004. Official APR language for PPR option 3 will be published in an upcoming issue of *Perspectives*. ▲

Other Perspectives Articles Covering This Topic

"JCAHO Offers Two Alternative Ways to Fulfill the Periodic Performance Review," October 2003, page 1

"Self Assessment Name Changed to Periodic Performance Review," May 2003, page 2

"Accreditation Timeline Charts Transition from Old Process to New Model," January 2003, page 1

"The Fact on Fiction: Misinformation on Shared Visions—New Pathways," November 2002, page 3

"Organizations to Test Their Own Compliance Through Self-Assessment," October 2002, page 6



OFFICIAL PUBLICATION OF REVISED ACCREDITATION PARTICIPATION REQUIREMENT

Periodic Performance Review

Full Periodic Performance Review

The organization must complete and transmit to the Joint Commission a Periodic Performance Review and plan of action and identify appropriate measures of success at the 18-month point in the accreditation cycle. The organization also participates in a conference call with Joint Commission staff to reach final agreement on the elements of the plan of action and measures of success. The plan of action addresses all standards areas identified as being not in compliance. At the time of the organization's triennial survey, the surveyors will validate whether the measures of success have been effectively implemented data indicate that performance has been sustained.

The results of the Periodic Performance Review do not affect an organization's accreditation decision at the 18-month point of the accreditation cycle. In the unlikely event that the Joint Commission or the organization identifies a continuing situation that represents a potential threat to health or safety through the Periodic Performance Review, a special announced survey will be initiated to facilitate resolution of the situation.

(For Hospitals Only) The hospital, in concert with the medical staff, demonstrates that physicians were appropriately involved in the completion of the Periodic Performance Review and development of plans of action.

Option 1

If the organization selects option 1 as an alternative to the full Periodic Performance Review, it must attest that after careful consideration with legal counsel, the organization has decided not to participate in the full Periodic Performance Review and instead will complete a Peri-

odic Performance Review and plan of action and identify appropriate measures of success at the 18-month point in the accreditation cycle. The organization may elect to participate in a conference call related to standards issues with Joint Commission staff at the 18-month point in the accreditation cycle. The plan of action addresses all standards areas identified as being not in compliance. At the time of the organization's triennial survey, the surveyors will validate whether the measures of success have been effectively implemented data indicate that performance has been sustained.

(For Hospitals Only) The hospital, in concert with the medical staff, demonstrates that physicians were appropriately involved in the completion of the Periodic Performance Review and development of plans of action.

Option 2

~~In lieu of~~ If the organization selects option 2 as an alternative to the full Periodic Performance Review ~~of Option 1, the organization-it~~ must attest that after careful consideration with legal counsel, the organization has decided not to participate in the Full Periodic Performance Review and instead intends to undergo a limited survey at ~~between the 17th and 18th month~~ the midpoint in its accreditation cycle. Following the survey, the organization must submit a plan of action with appropriate measures of success for any recommendation cited at the survey. The organization also participates in a conference call with Joint Commission staff to reach final agreement on the elements of the plan of action and measures of success. At the time of the organization's triennial survey, the surveyors will validate whether the measures of success have been effectively implemented data indicate that performance has been sustained.

On-Site Survey Brings **SHARED VISIONS—NEW PATHWAYS** to the Heart of Health Care Organizations

When Joint Commission surveyors arrive on site for full accreditation surveys in 2004, they will bring the new and unique **SHARED VISIONS—NEW PATHWAYS** survey process through the front doors—and throughout the units—of health care organizations across the country. Through this new process, surveyors will meet with health care organization staff in their units as they use the tracer methodology to follow the care path of patients, clients, or residents throughout an organization's units to see the direct provision of care, treatment, and services. In doing so, surveyors will ask staff members questions about the work they do every day in providing that care.

The new survey process focuses on organization-specific, priority care processes and systems by incorporating information from the Priority Focus Process (PFP) to concentrate the survey on areas that are most critical to each health care organization's successful provision of safe, high-quality care. By adding a midcycle assessment of standards through the Periodic Performance Review (PPR), the Joint Commission moves health care organizations to a more continuous accreditation process—one that focuses on using the standards everyday, 365 days a year, as an operational guide to providing safe, high quality care.

Survey Activities

The following is a brief summary of the activities in the new survey process. Every survey will be as unique as the organizations involved while consistently addressing these areas.

Opening Conference and Orientation. This first element of the survey allows for introductions among key organization staff and the surveyor(s). The organization will provide information about its purpose and structure to help guide the surveyors. This should not be a lengthy or elaborate presentation. For complex organizations, all services provided by the organization should be addressed. The surveyor(s) will briefly describe the structure of the survey and remind the organization of the data and information it will need to complete the next element of the survey, the survey planning session (a list of needed information is provided to the organizations prior to survey in the Survey Activity Guide, available on the "Jayco"™, organization-specific extranet).

Survey Planning Session. During this session, the surveyor(s) will review the data and information about the organization and plan the direction of the survey.

The surveyor(s) will select initial tracer patients, clients, or residents by reviewing the organization's top priority focus areas (PFAs) and clinical/service groups (CSGs) (identified through the PFP) to identify areas of care, treatment, and service and patient populations that are priorities for that organization. Surveyors will ask the organization to provide a list of patients, clients, or residents that address these areas, and select their initial tracers from the list provided.

If more than one surveyor is assigned to the survey, the surveyors will coordinate tracer activities so that more than one surveyor will not visit the same unit of an organization at the same time or need to speak to the same staff at the same time.

Surveyors will review achievement of the measures of success (MOS) contained in the plan of action from the Periodic Performance Review activities. If MOS are not required, the surveyors will review a statement prepared by the organization about the implementation of the plan.

Individual Tracer Activity. The tracer methodology will drive the majority of the new survey process. The tracer methodology is a way to analyze an organization's systems of providing care, treatment, and services using actual care recipients as the framework for assessing standards compliance. Surveyors will use the following general criteria to select initial individual tracers:

- Patients/clients/residents in top CSGs and PFAs for that organization
- Patients/clients/residents who cross programs, for example, long term care residents who present at a hospital or home care patients received from a hospital in complex organizations
- Patients/clients/residents related to system tracer topics (addressed below), such as infection control or medication management
- Patients/clients/residents receiving complex services, such as surgery or treatment in an intensive care unit

Other program-specific criteria for tracer selection has been identified and is listed in the Survey Activity Guide provided to all organizations undergoing survey.

Once individual tracers are identified for an organization, surveyors will "trace" the care provided to an individual by following how that care was provided throughout the organization to specific individuals. Surveyors will start where the care recipient is currently

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On-Site Survey Process (continued)

(Continued from page 11)

located. They then can move to where the individual first entered the organization's systems, an area of care provided to the individual that may be a priority for that organization, or to any areas in which the individual received care, treatment, or services. The order will vary. Along the way, surveyors will speak with health care staff members who actually provided the care to that tracer individual—or, if that staff member is not available, will speak with another staff member who provides the same type of care.

If a surveyor identifies a compliance issue, or if several surveyors on a team identify the same issue, the surveyor(s) may pull additional records to identify if the issue is isolated or represents a bigger system issue for the organization. Each tracer can take from an hour to three hours to complete. The average three-day survey will include 11 individual tracers.

System Tracer Activity. In addition to tracing care recipients throughout an organization, surveyors will also trace specific systems related to care. For 2004, the systems of medication management, infection control, and data use will be addressed. A system tracer for medication management could involve following the path of a particular medication through selection, procurement, storage, prescribing or ordering, preparing, dispensing, administration, and monitoring for effects. Surveyors will then meet with organization staff to discuss their overall medication management system. Topics of system tracers may change from year to year as the health care environment changes.

Proficiency Testing Validation and Regulatory Review (Laboratory Only). The Proficiency Testing Validation and Regulatory Review, two separate sessions, will only take place in surveys of laboratories. In Proficiency Testing Validation, surveyors will review the results of proficiency testing and review nonregulated analyte performance criteria if not included in proficiency testing.

In the Regulatory Review session, surveyors will verify that the laboratory is performing services according to CMS and state requirements, review CLIA certificates, and review state licenses as required of the laboratory and personnel.

Special Issue Resolution. This session provides an opportunity for surveyors to follow up on potential findings that could not be resolved in other survey activities. Depending on the findings, this could involve reviewing policies or procedures, reviewing additional clinical records to follow up on a tracer finding, review of personnel files, or discussions with selected staff.

Comprehensive Education for Surveyors

When a surveyor comes into an organization to conduct a full accreditation survey, he or she is [SHARED VISIONS—NEW PATHWAYS](#) to that organization, bringing the process to life. The Joint Commission has provided surveyors with multiple educational activities to arm them with the knowledge they need to conduct the new accreditation surveys.

Surveyors have been engaging in distance-learning on the new process throughout 2003. Three training CDs have been provided to surveyors, each containing at least 15 educational modules, each relating to a specific component of [SHARED VISIONS—NEW PATHWAYS](#). After reviewing the modules, surveyors were required to complete a self-assessment of what they learned from the module. They then submitted their assessment results to JCAHO Central Office to help review the learning process and identify additional learning needs.

Surveyors also participated in a series of conference calls focused on information provided to them on the survey activities discussed in this article.

A core cadre of approximately 40 surveyors who conducted the pilots of the [SHARED VISIONS—NEW PATHWAYS](#) process underwent intensive training in late 2002 and throughout 2003 on every aspect of the survey. These surveyors will serve as mentors for other surveyors and accompany them on 2004 surveys to assist with the transition process. JCAHO associate directors will also be observing these surveys to identify the need for additional surveyor training.

Additionally, at the beginning of January 2004, JCAHO will hold its 2004 Annual Invitational Training Conference to provide more comprehensive training on the new survey process to surveyors. This conference will include multiple sessions on role-playing in the [SHARED VISIONS—NEW PATHWAYS](#) survey process. More information on the surveyor conference will be provided in the February 2004 issue of *Perspectives*. Training and education will be ongoing throughout 2004.

Daily Briefing. In surveys lasting more than one day, surveyors will summarize for organization leadership the activities and findings of a day's survey at a daily briefing. This could involve commenting on positive findings or on issues that could lead to compliance problems. The organization will also have an opportunity to provide any information it did not provide during the previous day. There will be no daily briefing on the last scheduled day of survey.

Competence Assessment Process. During this session, surveyors and organization staff will discuss the organization's overall design of competence assessment processes for staff, licensed independent practitioners, and other credentialed practitioners, including the

processes' strengths and areas for improvement. Orientation, training, and education for these groups will also be discussed. This session will help surveyors determine an organization's level of compliance with relevant standards. This is not a record audit.

Medical Staff Credentialing and Privileging (Hospital Only). In hospital surveys, surveyors will meet with staff during this session to discuss the organization's process for collecting relevant data for appointment decisions. Other items for discussion include the following:

- Consistent implementation of the credentialing and privileging process for the medical staff and other LIPs who are privileged through the medical staff process
- Processes for granting privileges and for appropriate delineation of privileges
- Practitioners practicing within the limited scope of delineated privileges
- Links between the results of peer review and focused monitoring to the credentialing and privileging process
- Identification of vulnerabilities in the credentialing, privileging, and appointment process

Environment of Care Session. The environment of care (EC) session will be divided between group discussion on managing risk in the organization's environment (30% of session) and surveyor observation and evaluation of the organization's performance in managing EC risk (70% of the session). First, surveyors will review the organization's annual evaluations of its EC management plan and team meeting minutes of the EC multidisciplinary team to become better oriented to the organization's environment. Then surveyors and staff will discuss the environment to identify strengths and vulnerabilities in the organization's environment and actions necessary to address any vulnerabilities, and assess the organization's compliance with relevant standards.

Surveyors will then identify the EC management process they would like to observe based on the prior discussion. The surveyor will trace that EC activity through the organization to see it in action and identify any risk points in the process. Surveyors may also review EC issues as they move through an organization during a tracer.

Life Safety Code® Building Tour. Surveyors will tour those buildings of the organization that are required to be designed and maintained according to *Life Safety Code®* requirements. Through this tour, surveyors will identify vulnerabilities in the organization's

process for designing and maintaining buildings according to the code and for identifying and resolving code issues. Surveyors will then determine the organization's level of compliance with *Life Safety Code®* requirements.

Leadership Session. During the leadership activity, surveyors and organization leadership will meet to discuss organization-specific survey issues. That discussion could include the organization's performance in PFAs and the surveyors' assessment of links between standards compliance and PFA issues. The goal of this session is to "connect the dots" and tie specific findings to broader issues that affect the organization. Surveyors might address the process used by the organization to fulfill its PPR requirement, but this session will not cover MOS. Performance in systems of care, standards, or Accreditation Participation Requirements, including JCAHO's National Patient Safety Goals, could also be discussed.

CEO Exit Briefing and Organization Exit Conference. At the end of the survey, surveyors will meet with the organization's CEO to discuss the outcome of the survey, present and explain the Accreditation Report, and discuss any concerns the CEO has with the report. They will also identify any special arrangements for the Organization Exit Conference. For example, the CEO may not wish to share the Accreditation Report at that time.

During the Exit Conference, surveyors will discuss issues of standards compliance with the CEO and any organization leaders invited by the CEO to attend.

Relying on organization-specific information to guide the on-site portion of JCAHO's new accreditation process, the survey will be initially tailored to the specific issues and needs of that organization. This process will address the issues of care, treatment, and service at the heart of what every health care organization does, and serve as a powerful tool to improve the safety and quality of care that organizations provide to their communities. Initial survey findings could change the course of the rest of a survey. ▲

Other Perspectives Articles Covering This Topic

"Putting the Pieces Together Through a Revised Survey Process," October 2002, page 10

"Surveyor Group Trained for 2003 Pilot Surveys on Shared Visions—New Pathways," April 2003, page 1

Pilot Surveys Put New Process to the Test

When [SHARED VISIONS—NEW PATHWAYS](#) goes live on January 1, 2004, it will not be the first time the new process will spring into action. Every component of the new accreditation process has been tested—and tested again—through pilot surveys in health care organizations conducted throughout 2002 and 2003. These surveys, which tested all aspects of the accreditation process working together, were conducted in **ambulatory care, behavioral health care, home care** (including home health, hospice, and pharmacy), **hospital, laboratory, and long term care** organizations (including Medicare/Medicaid-based long term care accreditation).

“We greatly appreciate the involvement of the organizations in the pilot process,” says Carol Gilhooley, JCAHO’s director of accreditation process improvement. “We were able to refine the [SHARED VISIONS—NEW PATHWAYS](#) process after every pilot, so that what was tested at the end of the pilot period was a much better process than what was tested early on,” she notes. “We were able to refine, modify, and get a much better product as a result.”

A core cadre of approximately 40 surveyors, who were trained in December 2002 for the new accreditation process, conducted the pilot surveys. These surveyors will serve as coaches for other surveyors once [SHARED VISIONS—NEW PATHWAYS](#) is launched. Central Office staff also observed all the pilot surveys to evaluate the new process in action. Components tested in the pilot surveys include the following:

- Electronic application for accreditation (e-App)
- Full Periodic Performance Review
- Individual tracers
- System tracers, including medication management, infection control, and data use
- New scoring methodology
- New Accreditation Report
- New follow-up activity, including Evidence of Standards Compliance and measures of success

In addition, the unannounced survey process for 2006 was also pilot tested in some VA hospitals.

The pilot testing revealed two significant findings:

1. There were opportunities for improvement in some aspects of the new accreditation process
2. Health care organizations and surveyors involved in the pilots responded positively to many aspects of [SHARED VISIONS—NEW PATHWAYS](#)

Improvement Opportunities

Findings from the pilot surveys identified trends in five areas:

- **Logistical issues.** The pilots identified potential problems with scheduling of unit visits. In some early pilot surveys, two surveyors on a team would arrive at the

same unit at the same time, potentially causing undue burden to staff in that unit. In addition, some units were being visited more frequently than needed.

Improvement: To address these issues, JCAHO staff

- Created tools for surveyors to help them better plan their tracer activity
- Incorporated team-building education into surveyor training
- Added more surveyor meetings to the survey agenda to provide more opportunity for surveyors to consult on their tracer activities
- Assigned peer coaches to surveyors in early 2004 surveys to help with the transition to the new process

- **Accreditation Report format.** Some organizations felt that the Accreditation Report left by the surveyor on site during pilots did not clearly communicate systems issues or standards deficiencies.

Improvement: During the pilots, these reports were created manually. There is now more consistency with the automated format. In response to some of these concerns, JCAHO modified the format of the report to present information more clearly (see article, page 21, about the new report). In addition, surveyors will now explain the report to organization staff during the exit conference on survey.

- **Clinical/service groups identified through the Priority Focus Process.** Health care organizations, especially outside of hospital settings, felt that some of the clinical/service groups (CSGs) identified for their organizations through the Priority Focus Process (PFP) were too broad to be helpful in identifying individuals to serve as tracers (see article on page 5 for a discussion of CSGs).

Improvement: To make the CSGs more useful, JCAHO revised many of the CSG definitions in the PFP tool to make them clearer and more specific. In addition, questions will be added to the e-App for 2005 to collect more information about clinical populations, especially in non-hospital programs.

- **Technology issues with the Periodic Performance Review (PPR).** In completing the PPR component of the pilot surveys, some organizations experienced problems gaining access to their PPR tool as well as other problems related to the server. This improved toward the end of the testing period.

Improvement: To enable the PPR process to run more smoothly, JCAHO worked to increase the capacity on the server and address other technological issues with JCAHO’s information technology staff. In addition,

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Team Identifies Ways to Mitigate Risks in New Accreditation Process

With implementation of [SHARED VISIONS—NEW PATHWAYS](#) January 1, 2004, multiple new systems and processes will go live in tandem to make the new process a success. As with any new process, especially those relying heavily on new information technology systems, there are risks for glitches in the new accreditation process during the early phases of execution.

While the Joint Commission has taken significant steps to work out such potential glitches in 2003 through a series of system tests and pilot tests in health care organizations (see article, page 14), staff recognizes that implementing a number of new systems simultaneously makes problems a possibility.

As such, the Joint Commission has done what it advises health care organizations to do when redesigning a process—conduct a Failure Mode and Effects Analysis (FMEA) on [SHARED VISIONS—NEW PATHWAYS](#) and put meas-

ures in place to mitigate identified risks to the process' success.

FMEA is a team-based, systematic, and proactive approach for identifying the ways that a process or design can fail, why it might fail, and how it can be made safer. The purpose of performing an FMEA for JCAHO in relation to [SHARED VISIONS—NEW PATHWAYS](#) was to identify where and when possible system failures could occur and to prevent those problems before they happen. If a particular failure could not be prevented, then the goal would be to prevent the issue from affecting health care organizations in the accreditation process.

To begin an FMEA for JCAHO's new accreditation process, an internal team was formed with members from JCAHO's accreditation operations and information technology. The team received two education sessions

(Continued on page 16)

Pilot Surveys Put New Process to the Test *(continued)*

(Continued from page 14)

JCAHO's account representatives received training to help customers work through other technological issues with the PPR.

- **Scoring.** The scoring of standards and elements of performance in the pilot survey process was problematic because, at that time, there was no technology in place to support the scoring process. As such, surveyors had to manually score during the pilots rather than use laptops, as they will in official surveys. Moreover, because the scoring process is new under [SHARED VISIONS—NEW PATHWAYS](#), surveyors were experiencing a learning curve on the new system during pilots.
Improvement: Technology to support electronic scoring is now in place and will be in use for 2004 surveys. In addition, surveyors are receiving training on the new scoring process and will have the benefit of peer coaches on surveys early in 2004 to assist in their transition.

Positive Reactions

After each pilot survey, evaluations of the new process were sent to the health care organizations, as well as to the surveyors who participated and those individuals who were observers. These people had many positive comments about the new accreditation process. Findings include the following:

- 100% of pilot organizations responding felt that

[SHARED VISIONS—NEW PATHWAYS](#) is an improvement over JCAHO's traditional accreditation process

- 100% of pilot organizations responding indicated that the new process fosters a systems-level analysis that will help improve the quality and safety of care provided in an organization
- 100% of surveyors and pilot organizations found merit in the tracer methodology, noting that it is more in sync with normal operations in a health care organization, promotes value in staff-level interaction, and focuses on issues important to health care
- 92% of health care organizations felt that their staff were able to comfortably participate in the new accreditation process

The pilot survey process for [SHARED VISIONS—NEW PATHWAYS](#) provided JCAHO staff with very helpful information about opportunities for improvement while giving health care organizations the chance to experience and see the benefits of the new accreditation process. As such, the pilots provided for an improved process to launch in January 2004 and confirmed that the new accreditation process supports greater opportunity for improved safety and quality of care in health care organizations.

While there will still be opportunities to improve the new accreditation process as it is launched, pilot surveys have offered the chance to test, refine, and improve [SHARED VISIONS—NEW PATHWAYS](#) prior to implementation. ▲

Team Identifies Ways to Mitigate Risks *(continued)*

(Continued from page 15)

on FMEA and its applicability to the implementation of [SHARED VISIONS—NEW PATHWAYS](#) and then began reviewing all implementation elements. This involved creating a flow chart of the entire process and identifying process steps that rely on previous steps to achieve success. The team then began breaking down each of the main elements of the process into smaller groups of systems and procedures supporting that process. Through this drill-down technique, the team identified what it considers the most vulnerable parts of this process for implementation: *two weeks before full survey* and *48 hours after survey*.

“The team agreed to focus on these parts of the process because they involve some 20 different steps and the implementation of so many new components of the [SHARED VISIONS—NEW PATHWAYS](#) process, including the Priority Focus Process, the new accreditation manuals, new survey process, new scoring, new laptop program for the surveyors, and a new printing process for the Accreditation Reports,” explains Kurt Patton, executive director of JCAHO’s accreditation services. “We then investigated the probability of problems during these times, the detectability of those problems, and the criticality of those problems to the entire process should there be a failure.”

The team then identified ways to redesign some elements of the process where possible and built redundancies into the system to ensure greater success. A description of some of the outcomes of the FMEA for [SHARED VISIONS—NEW PATHWAYS](#) follows.

Mitigating Risks

As a result of the analysis conducted by JCAHO’s FMEA team, JCAHO has put several steps in place to help ensure successful implementation of the new accreditation process beyond what had already been built into the system.

Final Testing. One accreditation manager’s time was devoted entirely to supervising staff and providing oversight of testing the application of new survey technology—isolated from the other processes—with JCAHO’s information technology staff. New systems are also subjected to larger scale stress testing to mimic the day-to-day issues of multiple users performing multiple tasks. Lastly, “enterprise testing” was also completed to put the technology into the process flow and test how it works together with all the other processes involved.

Survey Volume. During January 2004 and February 2004, JCAHO has scheduled fewer surveys than usual so staff has time to carefully review the events of those initial surveys.

Priority Focus Process Review. JCAHO staff will be initially reviewing PFP output (see article, page 5) before it goes to each health care organization two weeks before survey to ensure that correct information is provided to the organization and surveyors.

Surveyor Training and Oversight. In addition to long-distance learning throughout 2003 and intensive training on the new accreditation process at the Joint Commission’s Annual Invitational Training Conference in early January 2004, surveyors will get extra guidance during survey. JCAHO associate directors from the department of surveyor management and development will be increasing survey observation to ensure that surveyors are implementing the new survey process appropriately. In addition, surveyor coaches who have surveyed

on the 2003 [SHARED VISIONS—NEW PATHWAYS](#) pilot surveys will also be coaching surveyors and helping surveyors apply the new process on site.

Accreditation Reports. Central Office staff members will initially receive reports from surveyors directly after survey, and they will be conducting quality checks on those reports before the reports go to the health care organization’s “Jayco” extranet site. This will help ensure consistency and accuracy particularly as

related to the new scoring guidelines.

Issues Database. Once [SHARED VISIONS—NEW PATHWAYS](#) goes live, accreditation program staff and IT staff will begin tracking any issues that arise during implementation and logging those issues into a database. From there, the issues can be identified, trended, and prioritized not in isolation but together as a group so that systemic issues can be identified and addressed quickly.

By applying FMEA to the implementation of [SHARED VISIONS—NEW PATHWAYS](#), JCAHO has proactively identified areas in the process that may be vulnerable to risk and, by developing mitigating processes, strengthened the process before official launch. While many of these mitigating processes may be necessary only during initial implementation, JCAHO will continue to analyze the process and make improvements to this new initiative. Input from accredited organizations will be especially important during the early stages of implementation so the process can continue to be refined. ▲

“We investigated the probability of problems, the detectability of those problems, and the criticality of those problems to the entire process.”

Accreditation Decision Process Supports Continuous Operational Improvement

The new accreditation decision process under **SHARED VISIONS—NEW PATHWAYS** has been revised to support the components of the new accreditation process, including the Periodic Performance Review (PPR), reformatted standards with elements of performance (EPs), and new follow-up activities after the PPR and the on-site survey. The “**SHARED VISIONS—NEW PATHWAYS: The New JCAHO Accreditation Process**” chapter of the 2004 accreditation manuals explains this process in detail and includes decision rules for each accreditation program.

The goal of the new accreditation decision and reporting approach is to move organizations away from focusing on achieving high scores to achieving and maintaining safe, high-quality systems of care, treatment, and services. During the decision process, there will be no numerical scores, and thus no scores will be disclosed to the organizations or to the public, subsequently shifting the focus from scores and the survey to continuous operational improvement.

The new decision process more directly shows the connection between organization performance, standards scoring, and final accreditation status.

Scoring Compliance with Elements of Performance

Scoring compliance has been revised as a result of the modified standards. EPs provide the specific measurable requirements of a standard that a surveyor will evaluate to determine overall compliance with a standard. EPs are evaluated on a three-point scale: insufficient compliance (0), partial compliance (1), and satisfactory compliance (2). In addition, an EP could be scored not applicable (NA) if its requirements do not apply to the care, treatment, or services offered by the organization.

Two components are scored for all EPs: compliance with the actual requirement and compliance with the track record for that requirement. Track records, which have always been part of JCAHO standards, represent the amount of time that an organization has been in compliance with a standard or EP. For all EPs, the track record is as follows:

Score	Initial Survey	Full Survey
2	4 months or more	12 months or more
1	2 to 3 months	6 to 11 months
0	Fewer than 2 months	Fewer than 6 months

Before determining compliance with a standard, compliance with its EPs must first be determined. Scoring compliance is affected by the criteria of the EP scoring category (A, B, or C) identified immediately preceding the scoring scale. There are three scoring criterion categories.

In **category A**, EPs relate to structural requirements (for example, policies or plans) that either exist or don't exist. These types of EPs are usually scored 2, if the policy or plan exists or 0 if it does not. However, partial compliance (1) can be achieved based on the track record, as described earlier. In addition, partial compliance can be achieved for category A EPs if the EP has multiple components designated by bullets. For these EPs, an organization must meet the requirements in *all* the bulleted items to get a score of 2. If the organization meets *none* of the requirements in the bullets, it receives a score of 0. If the organization meets *any* of the bulleted requirements, it will receive a score of 1 for the EP.

For example, EP 1 for PC.2.20 in the “Provision of Care, Treatment, and Services” chapter states the following:

“1. The organization's written definition of the data and information gathered during assessment and reassessment includes the following:

- The scope of assessment and reassessment activities by each discipline
- The content of the assessment and reassessment
- The criteria for when an additional or more in-depth assessment is done”

For an organization to score a 2 on this EP, its written definition would need to include all the information listed in the three bullets. To score a 1, it would need either one or two of the bulleted requirements in place. To score a 0, it would have none of the three bulleted requirements in place.

In **category B**, EPs may be structural or process requirements but also have a qualitative component. They are usually scored either 0 or 2 unless the quality, adequacy, or comprehensiveness of the compliance is not self-evident. B EPs are evaluated in two steps. This two-part evaluation applies to both simple and bulleted EPs. First, they are assessed to determine if the EP's requirements are present. If the EP has multiple components designated by bullets, as with the category A EPs, an organization must meet the requirements in *all* the bulleted items to get a score of 2. If the organization meets *none* of the requirements in the bullets, it receives a score of 0. If the organization meets *any* of the bulleted requirements, it will receive a score of 1 for the EPs.

If all the requirements are met, then a second step is implemented only if the surveyors (or organization staff conducting their PPR) have concerns about the quality of the process. In these cases, the organization must

(Continued on page 18)

Accreditation Decision Process (continued)

(Continued from page 17)

demonstrate that it has considered the principles of good process design shown in the sidebar, at right. The EP may be scored 2 if the organization considered all the applicable principles and meets the track record requirements for score 2. The EP may be scored 1 if the organization considered some of the applicable principles and/or meets the track record requirements for score 1. The EP may be scored 0 if the organization did not consider any of the applicable principles and/or meets the track record requirements for score 0. There is no need to apply the principles of good process design if the EP requirements are not met.

In **category C**, EPs are scored based on the number of times an organization does not meet a particular EP (for example, credentialing or medical record completion). This assumes an average sample size of 10. More information on sample size is included in the accreditation manuals and in the October 2003 issue of *Perspectives*, page 9. An EP is scored 2 if there is *no instance or one instance* of noncompliance with the EP, **and** the organization meets satisfactory track record requirements. It is scored 1 if there are *two instances* of noncompliance with the EP, **and/or** the organization meets partial track record requirements. It is scored 0 if there are *three or more* instances of noncompliance with the EP, **and/or** the organization has an insufficient track record of compliance. These instances of noncompliance must come from different sources, for example three different clinical records.

If an EP in the C category has multiple requirements designated by bullets, the following scoring guidelines apply:

- If there are fewer than 2 findings in all bullets, the EP is scored 2
- If there are three or more findings in all bullets, the EP is scored 0
- In all other combinations of findings, the EP is scored 1

For example: EP 3 of standard IM.6.40 on summary lists in the “Management of Information” chapter states the following:

“3. The list contains the following information:

- Known significant medical diagnoses and conditions
- Known significant operative and invasive procedures
- Known adverse and allergic drug reactions
- Know long-term medications, including current prescriptions, over-the-counter drugs, and herbal preparations”

In scoring this EP, an organization would receive a 2 if all of these four bulleted items were found to be noncompliant in fewer than two medical records. The EP would be scored 0 if an organization had three or more instances of noncompliance in all of the bulleted items in three or more medical records. Other combinations of findings

Principles of Good Process Design

Good process design has the following characteristics:

- Is consistent with your organization’s mission, values, and goals
- Meets the needs of patients, residents, or clients
- Reflects the use of currently accepted practices (doing the right thing, using resources responsibly, using practice guidelines)
- Incorporates current safety information and knowledge, such as sentinel event data and JCAHO National Patient Safety Goals
- Incorporates relevant performance improvement results
- Meets all components of the element of performance

would result in an EP score of 1. The EP would be scored 0 if all of the bullets were missing three or more times.

The table on page 20 summarizes scoring for EPs and standards.

Determining Standards Compliance

Under the new decision process, each standard is judged either “compliant” or “not compliant” based on the scoring of the EPs. A standard will be “not compliant” if any of its EPs is scored 0 (insufficient compliance) or 35% or more of its EPs are scored 1 (partial compliance). For any standard that is not compliant, an organization will receive a requirement for improvement, which must be addressed in an Evidence of Standards Compliance (ESC).

Follow-Up Activities

After the on-site survey, the survey team will transmit the results to JCAHO Central Office.

Reports that contain flagged items or the adverse decisions of Preliminary Denial of Accreditation or Conditional Accreditation will be processed by Central Office staff within 30 days of survey. At the time of survey, an item can be flagged for Central Office review by the surveyor if there is a question about interpreting or scoring a standard. Once that review is completed, the results of the survey are then posted to the organization’s secure “Jayco” extranet site.

If an organization is in compliance with all standards at the time of the on-site survey, it will be Accredited at that time. The official Accreditation Decision Categories for 2004 are included in the sidebar on page 19. If the organization is not compliant with one or more standards at the time of survey, it is required to submit an ESC report within 90 days of survey (starting July 1, 2005, within 45 days). As part of its ESC submission, the organization is required to demonstrate “correction” of not compliant standards (that is, detail the action(s) that it has taken—not just planned—to come into compliance with a standard) or “clarification” (explanation as to why the organization believes that it was compliant with a standard judged to be not compliant at the time

2004 Accreditation Decision Categories

Accredited—The organization is in compliance with all standards at the time of the on-site survey or has successfully addressed all requirements for improvement in an Evidence of Standards Compliance (ESC) within 90 days following the survey. Beginning July 1, 2005, the ESC will be due within 45 calendar days of the survey.

Provisional Accreditation—The organization fails to successfully address all requirements for improvement in an Evidence of Standards Compliance (ESC) report within 90 days following the survey. Beginning July 1, 2005, the ESC will be due within 45 calendar days of the survey.

Conditional Accreditation—The organization is not in substantial compliance with the standards, as usually evidenced by a count of the number of standards identified as not compliant at the time of survey that is between two and three standard deviations above the mean number of noncompliant standards for organizations in that accreditation program. The organization must remedy identified problem areas through preparation and submission of Evidence of Standards Compliance and subsequently undergo an on-site, follow-up survey.

Preliminary Denial of Accreditation—There is justification to deny accreditation to the organization as usually evidenced by a count of the number of noncompliant standards at the time of survey that is at least three standard deviations above the mean number of standards identified as not compliant for organizations in that accreditation program. The decision is subject to appeal prior to the determination to deny accreditation; the appeal process may also result in a decision other than Denial of Accreditation.

Denial of Accreditation—The organization has been denied accreditation. All review and appeal opportunities have been exhausted.

Preliminary Accreditation—The organization demonstrates compliance with selected standards in the first of two surveys conducted under the Early Survey Policy Option 1.

of survey). The organization's ESC must address compliance at the EP level and include a measure of success (MOS; if applicable) for each EP found to be partially (1) or insufficiently (0) compliant.

The organization's ESC submission will be evaluated by Central Office staff using the same scoring guidelines used by the surveyors at the time of survey and by health care organizations when they conduct their full PPR or PPR option 1. The ESC will be considered acceptable when the organization has demonstrated resolution of all requirements for improvement. If the organization's first ESC submission is determined to be acceptable, its decision will be Accredited, and it will be required to submit the data for applicable MOS, if required, for each EP four months later.

If it is determined that an organization's ESC submission is unacceptable, its accreditation decision will be Pro-

visional Accreditation, and it will be required to submit an acceptable ESC within 30 days. If the second ESC is determined to be acceptable, the organization's accreditation decision will remain Provisional Accreditation until it has submitted acceptable results of the corresponding MOS four months later. If the second ESC is determined to be unacceptable, a recommendation for Conditional Accreditation will be presented to the Accreditation Committee.

Central Office staff will evaluate the MOS results, when required. If it is determined that the MOS results are acceptable, no further action will be required of the organization, and if the organization had a Provisional Accreditation decision, its accreditation status will be changed to Accredited. If it is determined that an organization's MOS submission is unacceptable and its accreditation decision is not currently Provisional Accreditation, its accreditation status will be changed to Provisional Accreditation; the organization will be required to submit a second set of MOS results in another four months. If an organization whose accreditation decision is Provisional Accreditation because of an unacceptable first ESC submission, submits an unacceptable first measure of success submission, a recommendation for Conditional Accreditation will be presented to the Accreditation Committee.

If the organization's second MOS submission is determined to be acceptable, its accreditation decision will be changed to Accredited, and no further action will be required of the organization. If the second MOS submission is determined to be unacceptable, a recommendation for Conditional Accreditation will be presented to the Accreditation Committee.

Sustained implementation of the organization's ESC, including the MOS, are subject to review in random unannounced surveys.

A final decision letter will be mailed to an organization shortly after its ESC has been reviewed and an accreditation decision has been rendered. A Quality Report will then be posted on Quality Check® on the JCAHO Web site (see article, page 22). ▲

(Continued on page 20)

Other Perspectives Articles Covering This Topic

"New Decision Process, Accreditation and Performance Reports Under Consideration," October 2002, page 13

"2004 Decision Process Model Approved For Development," January 2003, page 4

"Evidence of Standards Compliance Due Within 90 Days of Survey January 2004–June 2005," July 2003, page 4

"2004 Aggregation and Decision Rules Approved for All Programs," August 2003, page 1

"Sample Sizes Set for Organization Assessment of Compliance," October 2003, page 9

Accreditation Decision Process *(continued)*

(Continued from page 19)

Scoring Guidelines

How to Score Standards

<u>EP Score</u>	<u>Standard Score</u>
All EPs scored 2	2
Any EP scored a 0	0
More than 65% of the EPs scored 2	2
Less than 65% of the EPs scored 2	0

How to Score Elements of Performance

	<u>Finding</u>	<u>EP Score</u>
Category A (Yes/No)	EP compliant	2
	EP not compliant	0
Category B (Yes/No and Process Design Principles)	EP not compliant	0
	EP compliant	2
	EP compliant; all principles present	2
	EP compliant; some principles present	1
	EP compliant; no principles present	0
Category C (Frequency- different sources)	EP noncompliance 1 or fewer times	2
	EP noncompliance 2 times	1
	EP noncompliance 3 or more times	0

How to Score EPs with Bullets

	<u>Finding</u>	<u>EP Score</u>
Categories A & B	All bullets in compliance	2
	All bullets not compliant	0
	Some bullets in compliance	1
Category C	Fewer than 2 findings across all bullets	2
	Three or more findings across all bullets	0
	All other combinations of findings	1

The New JCAHO Accreditation Report

To make the accreditation decision more meaningful to an accredited organization, JCAHO has significantly revised its Accreditation Report. The new report supports JCAHO's new accreditation process, [SHARED VISIONS—NEW PATHWAYS](#), by promoting a systems approach to safe and high-quality care.

Upon completion of a survey, the JCAHO survey team convenes and integrates its findings into one organizationwide Accreditation Report. Individual programs in the same organization (for example, hospital, long term care, home care) no longer have separate reports.

Components of the Accreditation Report

The Accreditation Report is composed of four sections. The first section is the “Executive Summary,” which appears on page one of the report. This is a summary of the accreditation decision and the follow-up activities (if any) needed by the organization, including timelines for those follow-up activities.

The second section addresses “Requirements for Improvement,” which are standards with which the organization is not compliant. A standard is not compliant if any one of its elements of performance (EPs) is scored not compliant (0) or if 35% or more of its EPs are scored partial compliance (1). Therefore, a standard is compliant if 65% or more of its EPs are scored satisfactory (2) and none of its EPs are scored 0.

The requirements for improvement are sorted in the report by priority focus areas (PFAs) to help organizations focus performance improvement activities on potential systems issues. (See article, page 5, for more information on PFAs.) Below the applicable PFA, each requirement for improvement is listed by the standard number, the text of the standard, the applicable program(s), the findings of the survey team, the EPs found to be partially compliant or insufficiently compliant, and the secondary PFA(s).

The “*Life Safety Code*® Report” is the third section in the new Accreditation Report. This section appears only if issues were identified in the organization's compliance with the *Life Safety Code*. Organizations are required to follow-up on these issues as they would other requirements for improvement.

Finally, the “Supplemental Findings” section appears at the end of the report. Supplemental findings are standards with which the organization is compliant, but contain EPs that have been scored at the partial compli-

ance level. In other words, the partially compliant EPs did not cause the standard to be scored not compliant. Similar to the “Requirements for Improvement” section, the supplemental findings are sorted by PFAs. Below the applicable PFA, each supplemental finding will be listed by the standard number, the text of the standard, the applicable programs, the findings of the survey team, the EPs found to be partially compliant, and the secondary PFA(s).

There is no overall score or grid element score with the new process, and no scores are shared with the organization in their Accreditation Report. The new report and accreditation process focus less on scores and more on using the standards to achieve and maintain excellent operational systems.

The surveyors present the Accreditation Report to the organization at the survey exit conference at which time they will explain the report to organization staff. The report is left on site with the organization and is also posted on the organization's secure, password-protected extranet Web site approximately 48 hours after survey.

For sample pages from an accreditation report, see pages 26 and 27.

Follow-up Activities

If an organization is in compliance with all applicable standards at the time of the survey, it is deemed “Accredited” at that time. If the organization is not compliant with one or more standards at the time of survey, it is required to submit an Evidence of Standards Compliance (ESC) Report including measures of success (MOS), where applicable, within 90 days of survey (starting July 1, 2005, within 45 days). If the organization's ESC is deemed acceptable, its accreditation status will be listed as “Accredited.” A completed MOS form is due four months from notification of an approved ESC Report, as applicable. (See decision process article on page 17, for more information on ESC.)

Supplemental findings do not require an ESC report to be submitted to JCAHO.

A final decision letter is posted to the organization's Web site shortly after the ESC is reviewed and an accreditation decision is rendered. The Quality Report is then posted on Quality Check® on the JCAHO Web site. (See article, page 22, for more on the Quality Report.) ▲

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Quality Report Receives Additional Improvements Prior to Launch

One of the Joint Commission's goals for [SHARED VISIONS—NEW PATHWAYS](#) is to improve the value and relevance of the information provided to the public about health care organizations. By doing so, JCAHO hopes that it will help the public make better informed decisions about their own health care. The main tool by which JCAHO will disseminate this information is the Quality Report. The Quality Report will replace the current Performance Report over the next three years. The report will be most useful in its electronic form, with links to helpful definitions and additional information designed to aid in the viewer's understanding of the information in the report. A print version of the report, as well as a users guide, will also be available.

Report Contents






Since an organization must be in full compliance with all standards to achieve a decision of "Accredited" under the new accreditation process, there will be no scores for standards compliance in the Quality Report.

The major sections of the report are as follows:

- **What is accreditation?** This is a summary for the public on what it takes and what it means to be a JCAHO-accredited health care organization.
- **Summary of Quality Information.** This section provides an overview of all the quality of care components included in the rest of the report for a given organization, including Joint Commission-recognized quality awards, the organization's accreditation decision, accredited sites and services, and an overall assessment of an organization's performance against JCAHO's National Patient Safety Goals, JCAHO's National Quality Improvement Goals, and the Center for Medicare and Medicaid Services' (CMS) Patient Experience of Care Results.
- **Detailed information.** Subsequent pages of the report give more detailed information about the organization's performance in each of these areas.

Quality Report Key

KEY

-  This Organization Achieved the Best Possible Results
-  This Organization's Performance Is Better Than Most Accredited Organizations
-  This Organization's Performance Is Similar to Other Accredited Organizations
-  This Organization's Performance Is Below Most Accredited Organizations
-  This Measure Is Not Applicable for This Organization

Enhanced Quality Check®

In addition to the improvements in the Quality Report itself, JCAHO is currently working on revisions to the functionality of its Quality Check® search engine. Quality Check is available on JCAHO's Web site to provide information about health care organizations. When complete in early 2004, the revised search engine should have two tracks available—one for a consumer search and one for a health care professional search. Consumers will search by type of provider, type of care, organization location, and organization name. Health care professionals will search by accreditation program, type of care, organization location, organization name, and JCAHO organization identification (ID) number.

The organization's performance in the summary as well as the detailed sections for National Patient Safety Goals, National Quality Improvement Goals, and Patient Experience of Care results will be displayed using a five-element key (see below), displaying the following:

- A star (★) indicates that the organization has achieved the best possible performance in this area. This symbol was added to the key recently to acknowledge those organizations that achieve 100% compliance in an area. All organizations are expected to continue their quality improvement efforts in a given area until they have reached 100% compliance and then maintain it.
- A plus sign (+) indicates that the organization's performance is above the average performance of most accredited health care organizations. The organization's performance must be statistically better than most accredited organizations using a 99% confidence interval. Only about 5% of organizations will receive a plus on any given measure.
- A checkmark (✓) designates that the organization's performance is similar to that of most other accredited organizations (approximately 90%). This is where the majority of organization's performance will fall. In promoting the Quality Report, the public will be encouraged to look for the check.
- A minus sign (−) denotes that the organization's performance is below the performance of most other accredited organizations. The organization's performance must be statistically below most accredited organizations using a 99% confidence interval. Approximately 5% of organizations will receive a minus on any given measure.

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Security Measures Protect Integrity of SHARED VISIONS–NEW PATHWAYS Systems

Through [SHARED VISIONS–NEW PATHWAYS](#), the Joint Commission is using technology to communicate with health care organizations in new and powerful ways. In November 2003, the “Jayco”™ Online extranet site was launched to provide organizations in all accreditation programs with access to new features, general accreditation resources, and important information specific to each organization’s accreditation experience. This communication portal is a secure, password-protected connection with the Joint Commission that will make information exchange much more efficient and ensure that each organization has real time access to all survey findings.

One of the new features available via “Jayco” is the Periodic Performance Review (PPR). This tool will be used by health care organizations to first identify their approach to the PPR and ultimately, if they choose the full PPR, to document their evaluation findings. When an organization accesses the PPR, all processing takes place on secure Joint Commission computers.

As with any technology-based process that takes advantage of the Internet, there can be an increased security risk. To address this issue, the Joint Commission conducted a comprehensive assessment of its security policies and procedures.

“When most people think of security breaches they primarily think of hackers,” notes George Morris, JCAHO’s vice president of information technology. “Although we remain on guard for such attacks, they don’t represent the greatest danger. We really don’t have any data of ‘street value,’ such as credit card numbers, trade secrets, or financial reports. Our greatest security risks come from viruses, spam, or inadvertent data disclosure,” he says.

Based on the outcome of the security assessment, new measures were implemented to significantly reduce exposure to JCAHO primary and secondary risk areas. JCAHO’s primary risk areas of viruses, spam, and accidental data disclosure, are addressed by the following strategies:

- DMZ and firewalls
- Robust authentication and authorization
- Security patches for all servers and desktop workstations
- Encryption
- Spam-filtering services
- Virus protection

The Joint Commission’s secondary risk areas are hijacked servers, HTML exploits, and site destruction. The following security measures were adopted to address these issues:

- Security-focused code reviews
- Intrusion detection
- Penetration audits
- A business continuity plan, which allows JCAHO to pull all its accreditation systems off-line and move to a remote site to continue operation with minimal interruption until all systems can be restored

While no technology system connected to the Internet is completely secure, with all these measures in place, potential impact of a security breach has been significantly reduced. The Joint Commission is committed to a proactive policy of prevention, while having a robust incident response system in place.

“The Joint Commission is committed to a proactive policy of prevention.”

Planned Improvements

As [SHARED VISIONS–NEW PATHWAYS](#) systems are implemented, future improvements are already planned. JCAHO plans to provide multiple IDs to the “Jayco” site per health care organization so more than one person can have access to the site, at the organization’s discretion. JCAHO also plans to make maintenance of ID and passwords available to the health care organization, so that they have greater control over access to their data, issuing and deleting IDs as needed. Finally, JCAHO plans to provide role-based authentication and authorization to organization-specific information so that, for example, an organization’s CEO may have access to all information on a site while other staff members may only have access to information for which they are responsible. This will be particularly helpful to complex organizations with multiple locations that desire to classify the information displayed. ▲

JCAHO Evaluation Plan Expanded for SHARED VISIONS–NEW PATHWAYS

Any good performance improvement initiative includes the evaluation and analysis of results once the initiative is implemented to determine the effectiveness of the changes and the need for revisions to the process as indicated by those results.

The Joint Commission has always sought feedback from accredited health care organizations on its accreditation processes. In the past, customer feedback had been solicited when an organization submitted its electronic Application for Accreditation (e-App) and postsurvey in the form of surveyor and survey process evaluations, and CEO opinion surveys. Surveyors' feedback was also sought in peer evaluations. However, the level of change and reliance on technology associated with SHARED VISIONS–NEW PATHWAYS dictates the need for more detailed, automated evaluations on the new accreditation process.

With that need in mind, JCAHO staff expanded and improved the evaluation process to increase the opportunities to provide feedback and tie those opportunities more directly to the stages of the accreditation process. At the same time, evaluation was redesigned to rely more on automated reporting to improve efficiency and the level of detail at which feedback can be analyzed.

The evaluation process was revised with the following objectives:

- Automate the evaluation tools, when possible, so health care organizations can submit their feedback on a secure, organization-specific extranet site
- Collect specific feedback at key “points-of-contact” in the accreditation process
- Eventually reduce the overall volume of questions in each evaluation tool
- Eliminate the duplication of questions across the evaluation tools

Points of Contact

In expanding the evaluation process, JCAHO staff felt that the detail and submission of feedback would be improved if it were solicited at or closely after key elements of the accreditation process. For health care organizations, this

means at or after interacting with Joint Commission staff and/or processes when these experiences are fresh in the minds of staff participating. Feedback on the SHARED VISIONS–NEW PATHWAYS accreditation process will be sought at the following points in the process on the elements identified:

- At submission of Periodic Performance Review (PPR)—organization evaluation of standards, Priority Focus Process, and PPR
- At submission of e-App—organization evaluation of the application process
- After survey is scheduled—organization evaluation of scheduling process
- After survey is complete—surveyor evaluation of survey process, standards, and of peer surveyors
- After the survey report is posted to an organization's extranet—organization evaluation of their surveyor(s), the survey process, and the PFP
- After submission of Evidence of Standards Compliance (ESC) and measures of success (MOS)—organization evaluation of the ESC process
- After accreditation decision is rendered—anonymous print CEO opinion survey

“JCAHO increased the opportunities to provide feedback and tied those opportunities more directly to the stages of the accreditation process.”

A consistent five-point evaluation scale will be applied to each of these evaluations. The evaluations will begin in hard copy only for the first quarter of 2004 as the technology needed to support automated feedback is developed. Beginning in the second quarter of 2004, these evaluations will become automated, except for the CEO opinion survey, which is sent to organization CEOs in hard copy.

Going Forward

Joint Commission staff is currently developing a plan for analyzing the data gleaned from these evaluations. Key JCAHO stakeholders, including the Joint Commission Board of Commissioners and Accreditation Committee, will receive regular reports on these data to confirm the strengths of SHARED VISIONS–NEW PATHWAYS and identify opportunities for improvement in this evolving accreditation process. ▲

Quality Report Receives Additional Improvements (*continued*)

(Continued from page 22)

- “N/A” will be shown if the measure is not applicable to the organization.

The Joint Commission also recently revised the format used in the Quality Report to report National Quality Improvement Goals to align it with the format used by CMS in its National Hospital Voluntary Reporting Initiative. In addition to showing the results using the symbols described above, the report will also include the percentage of compliance—the number of times the organization performed the recommended procedure during the time period being reported. For example, the report may list that the organization gave aspirin at arrival to 91% of 112 eligible patients treated for heart attack. This consistency in reporting of data supports the goal of comparable reporting between JCAHO’s Quality Report and CMS’ National Hospital Voluntary Reporting Initiative.

The Quality Report User Guide

To facilitate understanding about the elements of the Quality Report, “A Guide to Using the Joint Commission Quality Report” will also be made available to the public with the Quality Report beginning in July 2004. This guide gives a greater level of detail about every element of the report and breaks them out in easy to understand diagrams. The guide also includes appendices explaining how each of the measures is calculated to achieve what appears

in the report, including the roll-up methodology for measure-set reporting. This guide was posted on an organization’s “Jayco” site for feedback from health care organizations in December 2003. It will be posted on JCAHO’s Web site in February 2004 for public feedback. Accredited organizations will be able to view their individual public reports in June 2004, one month before public release.

Report Posting

A Quality Report will be posted to an organization’s home page on “Jayco” 48 to 72 hours after an organization’s full survey for only the organization to review. The report will be posted for public viewing on JCAHO’s Quality Check® shortly after if the organization has no requirements for improvement. If it does, the Quality Report will not post for the public until after an organization’s Evidence of Standards Compliance (ESC) is received and approved by JCAHO—approximately 90 days after the organization’s survey is complete (45 days beginning July 1, 2005). ▲

Other *Perspectives* Articles Covering This Topic

“New Decision Process, Accreditation and Performance Reports Under Consideration,” October 2002, page 13

“New JCAHO Quality Report Provides Meaningful, Relevant Information,” July 2003, page 1

Clinical/Service Groups and Priority Focus Areas (*continued*)

(Continued from page 6)

Priority Focus Process Output (*Continued*)

Laboratories

- Blood donor center
- Chemistry
- Clinical cytogenetics immunogenetics
- Diagnostic immunology
- Embryology
- Hematology
- Histocompatibility
- Immunohematology
- Microbiology
- Molecular biology
- Pathology
- PPMP³ testing services
- Radiobioassay

³ Provider-performed microscopic procedures

- Tissue storage
- Waived services

Long Term Care

Long Term Care

- LTC—Hospital operated
- LTC—Freestanding
- Residents needing subacute care

Additional LTC Based on CMS’ Nursing Home Compare Data

- Residents having delirium
- Residents having infections
- Residents having loss of ability in activities of daily living

- Residents having mobility concerns
- Residents having pressure ulcers
- Residents needing pain control
- Residents needing physical restraints

Office-Based Surgery

- Cardiac catheterization
- Endoscopy
- Gastroenterology procedures
- General surgery
- In vitro fertilization
- Ophthalmology
- Oral maxillofacial surgery

- Orthopedic surgery
- Plastic surgery
- Podiatric surgery
- Trigger point injections (pain management)
- Urologic procedures

Preferred Provider Organization

- Preferred Provider Organization
- Other

PRIORITY FOCUS AREAS FOR ALL PROGRAMS

- Assessment and care/services (this is replaced with “Analytic processes” for laboratories)

- Communication
- Credentialed practitioners
- Equipment use
- Infection control
- Information management
- Medication management (this does not apply to laboratories)
- Organizational structure
- Orientation and training
- Rights and ethics
- Physical environment
- Quality improvement expertise and activity
- Patient safety
- Staffing

The New JCAHO Accreditation Report *(continued)*

(Continued from page 21)

Sample Accreditation Report



Springfield

123 Main Street
Springfield, AnyState, 90210

Organization Identification Number: 8675309

DATES OF SURVEY 3/21/2004 – 3/24/2004

PROGRAM(S)

Any Accreditation Program

SURVEYOR(S)

Tom Smith, MD

Executive Summary

Based upon the findings of this Accreditation Survey, your organization's survey findings require follow-up to the Joint Commission. A completed Evidence of Standards Compliance (ESC) form is due in 3 months and a completed Measurement of Success (MOS) form is due four (4) months from notification of a successful ESC. Successful completion of the ESC will result in Accreditation and unsuccessful completion of the ESC will result in Provisional Accreditation. We congratulate you on your efforts to provide high quality care for those you serve.

Accreditation Survey Findings

Requirement for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Medication Management

Program: ANY

Standard: MM.2.20

Standard Text: Medications are properly and safely stored throughout the organization.

Secondary Priority Focus Area(s): Patient Safety, Equipment Use, Physical Environment

Elements of Performance

2. Medications are stored under necessary conditions to ensure stability.

Surveyor Findings

Medications in the possession of the organization, specifically emergency drug kits, were not stored under proper conditions to ensure stability. The medications were routinely in an area with very high humidity.

Sample Accreditation Report (*Continued*)

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Communication

Program: ANY

Standard: LD.3.90

Standard Text: Services provided by consultation, contractual arrangements, or other agreements are provided safely and effectively.

Secondary Priority Focus Area(s): Organizational Structure, Quality Improvement Expertise & Activity

Elements of Performance

1. The leaders approve sources for the organization's services that are provided by consultation, contractual arrangements, or other agreements.
2. The clinical leaders advise the leaders on the sources of clinical services to be provided by consultation, contractual arrangements, or other agreements.
7. The organization evaluates the contracted care and services to determine whether they are being provided according to the contract and the level of safety and quality the organization expects.

Surveyor Findings

The contract for drug screens, for the behavioral health program, has not been approved by the organizations leaders. Clinical leaders did not advise organization leaders on the contract for drug screens. The organization has not evaluated the drug screen contract since it was established.

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Rights and Ethics

Program: ANY

Standard: RI.2.70

Standard Text: The organization addresses advance directives

Secondary Priority Focus Area(s): Assessment, Communication, Information Management

Elements of Performance

9. The organization's policies address advance directives and specify whether the organization will honor the directives.

Surveyor Findings

During an interview with staff and management, it was determined that the organization has not determined policies and procedures for how advanced directives apply to the outpatient setting.

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Staffing

Program: ANY

Standard: HR.1.10

Standard Text: The organization provides an adequate number and skill mix of staff consistent with the organization's staffing plan.

Secondary Priority Focus Area(s): Orientation & Training

Elements of Performance

1. There is an adequate number and skill mix of staff to meet the care, treatment, and service needs of the individuals served.

Surveyor Findings

Based upon the organization's staffing plan, an inadequate number of nursing staff was available on 12/07/03, 12/11/03, and 01/31/04.

Supplemental Findings

There are no Supplemental Findings.



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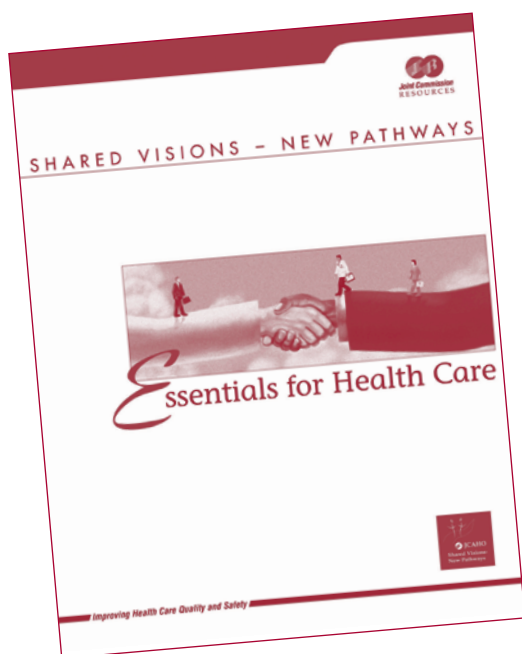
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